HUMANA'S YourPractice

Humana Named Top Payer by PayerView

Humana is proud to be named as PayerView's number one payer among all payers, which reflects Humana's strong commitment to the health care provider community. Humana has been named top payer based on a review of 2012 claims payment data conducted by athenahealth and *Physicians Practice*.

Humana is the highest performing payer in all of PayerView, which seeks to provide an objective, quantitative measure of health care providers' "ease of doing business" with individual payers by aggregating the activity of 40,000 health care providers, reviewing 83 million transactions and $15 billion in charges.

Being named the easiest payer with which health care providers do business is something Humana has worked hard to achieve. Bruce Perkins, President of Humana's Healthcare Services segment, said the ranking demonstrates that the cornerstone of Humana's integrated care delivery model – enriched data integration among health care providers, clinicians and caregivers – is working for health care providers by creating a more effective and more efficient, member-focused model of care.

In addition, Humana also maintained its first-place ranking for eligibility accuracy. This means Humana includes more accurate member plan benefit information, saving the member and health care provider time and hassle.

Other athenahealth PayerView Humana highlights include:

- Humana had the best performance for days in accounts receivable (DAR) among major payers and national commercial payers, representing a 12 percent improvement from last year.
- Humana had the highest ranked electronic remittance advice (ERA) transparency rate among major payers.
- Humana also performed well in new metrics, tying for first place in enrollment efficiency among major payers.

Data for the 2013 PayerView rankings were derived from athenahealth's athenaNet® system database. Complete data from the 2013 PayerView study can be found online at www.athenahealth.com/payerview.

Provider Organized Delivery Systems (PODS) Seeks to Support Health Care Providers

Dear physicians and office staff:

I'm pleased to tell you about a new Humana program called the Provider Organized Delivery Systems, or PODS for short. The PODS program is designed to support health care providers with tools that focus on coordinating communication between all participants in a member's care, as well as improving practice efficiency.

The PODS program focuses on Humana's Medicare Advantage members in Preferred Provider Organizations (PPO), Private Fee-for-Service (PFFS) and nonrisk HMO groups. PODS is designed to give you centralized support that will assist you in providing our Medicare Advantage members with valuable services, thereby encouraging them to make informed decisions about their health and well-being. Greatest care management focus is placed on complex-chronic members and special needs plan (SNP) members.

The PODS program has three principle objectives:

1. Care management through increased participation levels in clinical programs, added utilization of primary care resources and home-based services
2. Improved documentation through increased accuracy of diagnosis coding
3. Improved quality by closing gaps in care and working to improve medication adherence and patient safety

To accomplish these objectives, health care providers in each region are grouped into PODS. A team of Humana associates is then assigned to work with and support the individual health care providers.

The PODS team consists of the following:

- The PODS owner who manages the PODS team and coordinates and defines the strategy of visits to the health care provider
- The care coordinator who coordinates clinical program referrals
- A Medicare risk adjustment (MRA) representative who provides education to health care providers and their staff members to improve coding accuracy
- An analyst who manages reporting, performs provider-level analysis and provides data-driven recommendations
- A provider consultant who manages provider relations

Your PODS team can provide practice-level, physician-level and member-level reports. The reports are updated monthly and are distributed during scheduled visits by the PODS provider representative and include:

- HEDIS compliance
- Attributed Humana patient volume
- Primary care physician visits
- Completed wellness visits
- Emergency room visits

- Acute admissions
- Readmissions
- Humana clinical program participation
- Gaps in care
- Potential documentation opportunities

For more information about the PODS program, please contact Ashley Warrick at awarrick@humana.com.

Sincerely,

George A. Andrews, MD

George A. Andrews, M.D., M.B.A., F.A.C.P., F.A.C.C., F.C.C.P.

Prepare for 2014 Health Care Reform Changes

As consumers prepare for 2014 health care reform changes, Humana encourages health care providers to educate themselves. Major provisions of the Affordable Care Act (ACA) become effective in 2014, including the requirement that nearly all Americans have health insurance coverage, or face a tax penalty.

New programs have been created for those in certain income ranges to help them shop for and pay for their health insurance, including advance tax credits, subsidies, Medicaid expansion and health insurance marketplaces.

Where can people shop for and buy individual insurance?

Health care reform builds on the existing private insurance system.

While many consumers may have access to group health insurance through their employers, for those shopping for individual health insurance, there are new options to consider.

Starting in October 2013, in addition to buying individual health insurance from Humana or through an agent, Americans will have access to a health insurance marketplace, also known as the exchange, where they can shop for and compare different private health insurance plans for 2014.

The marketplaces won't offer their own health insurance plans. They'll offer a variety of options from private health insurance companies, like Humana.

How do these changes affect health care providers?

If they aren't already getting them, health care providers can expect questions from their patients, who may be confused and anxious about these changes. Humana has robust resources for consumers who may be feeling overwhelmed. Health care providers can recommend patients visit Humana.com/HealthcareForYou to get more information.

Next, health care providers are encouraged to prepare for an influx of new patients in 2014. Americans who may have delayed preventive health care visits or services due to a lack of health insurance will now be able to seek those services with 100 percent coverage. This is great news for their health! For health care providers, the demand may be overwhelming. Humana recommends that health care providers educate their office staff about the increased demand and develop a strategy to serve a large number of new patients.

How can health care providers learn more?

To learn more about health care reform, health care providers may want to contact professional organizations or advocacy groups, such as the American Medical Association.

Humana Updates Commercial Preauthorization and Notification List Effective September 14, 2013

On Sept. 14, 2013, Humana will implement an updated preauthorization and notification list for all commercial fully insured plans [e.g., health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO) and exclusive provider organization (EPO)]. Please note that precertification, preadmission, preauthorization and notification requirements all refer to the same process of preauthorization. In addition, certain services outlined in the preauthorization and notification lists may not be applicable for Chicago, Nevada or California health care providers affiliated with an independent physician association (IPA) via a capitated arrangement. Health care providers may refer to their provider agreements for additional information or requirements concerning preauthorization.

Updates to the list include the addition of outpatient transthoracic echocardiogram (TTE) and outpatient coronary angioplasty/stent procedures.

The lists are available here (https://www.humana.com/provider/medical-providers/education/claims/pre-authorization). Office staff members may also call the phone number on the back of the member's identification (ID) card to determine if a service requires preauthorization.

Important Notes:

- **Commercial HMO members:** The full list of commercial preauthorization requirements applies to Humana commercial HMO members.

- **Administrative Services Only (ASO) groups:** It is important to note that some employer groups for which Humana provides administrative services only (self-insured, employer-sponsored programs) may customize their plans with different requirements.

Failure to obtain preauthorization for a service or listed medication could result in financial penalties for the health care provider and the member, based on the provider's contract and the member's certificate of coverage. If a health care provider doesn't request authorization for a service indicated on the updated preauthorization and notification list, the claim may be subject to retrospective medical necessity review and may not be paid if it is determined not to be medically necessary. If a provider does not request preauthorization, but the service or medication is considered medically necessary, then the provider or the member may be assessed the preauthorization penalty described in the provider's contract or the member's certificate of coverage. An authorization does not guarantee payment, and any payment or coverage determination will be based upon all of the provisions of the member's certificate or evidence of coverage (benefit plan document), which is in effect at the time a service is performed.

Humana recommends that an individual practitioner making a specific request for services or medications verify benefits and authorization requirements before providing services.

For more information, contact Humana clinical intake team at 1-800-523-0023.

Limited Income Newly Eligible Transition Program Assists Members

By providing immediate-need prescription drug coverage, the Limited Income Newly Eligible Transition (LI NET) program helps qualified individuals get the medication they need.

What is LI NET?

Humana administers the LI NET program on behalf of the Centers for Medicare & Medicaid Services (CMS).

The purpose of the LI NET program is to help individuals with Medicare's low-income subsidy (LIS) who are not yet enrolled in a Part D prescription drug plan, obtain immediate prescription drug coverage. Also, the LI NET program provides retroactive coverage for new "dual eligibles" (those individuals who are eligible for both Medicare and Medicaid or Medicare and Supplemental Security Income from the Social Security Administration). Medicare automatically enrolls these individuals into LI NET with an effective date retroactive to the start of their full benefit dual status or their last enrollment in a Medicare Part D plan, whichever is later. These individuals are covered by the Limited Income NET program temporarily while Medicare enrolls them into a standard Medicare Part D plan for the future.

The Centers for Medicare & Medicaid Services (CMS) created this program to provide point-of-sale prescription drug coverage for qualified individuals. Participants in the program receive this benefit right at the pharmacy.

While the LI NET program is a pharmacy benefits program, Humana is working to increase awareness of the program among health care providers and ultimately, their patients who may qualify. For more information about the LI NET

program, health care providers can visit Humana.com/LINET (https://www.humana.com/provider/pharmacists/pharmacy-services/linet-information?cm_mmc_o=ZAFzEzCjCezEbfY%20Jq1CjCezEbfY%20Jq1CjCZAFzEz.gBF%2fkbEwf%20ezEbfY%20Jq1).

CMS Updates Risk Adjustment Model to 79 HCC Version

The Centers for Medicare & Medicaid Services (CMS) is introducing a revised medical risk adjustment model with 79 Hierarchical Condition Categories (HCCs) for the 2014 payment year (2013 dates of service). The new HCC model is intended to take into account new ICD-9 codes created in the last decade and to improve the model's ability to predict expenditure by removing diagnosis codes subject to discretionary or inappropriate coding. (CMS 2014 Final Announcement, pp. 29-30)

In the April 1, 2013, final payment letter, CMS announced that a blended HCC model would be used to calculate 2014 risk scores in order to mitigate the impact on risk scores for some Medicare Advantage (MA) plans. This blended HCC model will be a mix of the former 70-HCC model and the new 79-HCC model.

Health care providers need to be aware of the following about the blended HCC medical model for 2013 dates of service:

- Risk scores will be based on a blend of the existing 70-HCC model (25 percent) and the new 79-HCC model (75 percent). The final blended risk score will be used to determine reimbursement for each member.
- Full implementation of the 79-HCC model will start with 2014 dates of service.
- There are 3,162 diagnosis codes in the blended models: 2,885 from the 70-HCC model and 3,033 from the 79-HCC model. The two HCC models share 2,809 diagnosis codes.
- There are 224 new diagnosis codes introduced in the 79-HCC model.
- There are 129 diagnosis codes in the 70-HCC model that have been dropped in the 79-HCC model.
- For 2013 dates of service, risk scores will continue to include HCCs from the 70-HCC model, including:
    - Old myocardial infarction (HCC 83)
    - Chronic kidney disease, Stages 1-3 (HCC 131)
    - Nephritis (HCC 132) and unspecified kidney disease (HCC 131)
    - Full range of polyneuropathy diagnosis codes (HCC 71)

A member's health status will need to be accurately reflected in the medical record documentation and accurately reflected on the claim/encounter form. According to CMS, "The CMS-HCC model depends upon accurate diagnosis coding, which means that the physicians must fully understand and comply with documentation and coding guidelines for reporting diagnoses."

For more information about the new HCC model, health care providers can send an email to MRAeducation@Humana.com.

Immunization Administration Requires Immunization Code on Claims

As flu and pneumonia immunization season grows closer, Humana reminds health care providers that claims for administration of vaccines must also include the vaccine itself.

Important notes:

- Report administration of influenza virus vaccine, pneumococcal vaccine or hepatitis B vaccine with Healthcare Common Procedure Coding System (HCPCS) codes G0008, G0009 or G0010 for Humana Medicare Advantage.
- Code administration of all immunizations (except for influenza, pneumococcal or hepatitis B vaccines) on a single date of service from either of the following two code ranges: 90460 to 90461 or 90471 to 90474, according to National Correct Coding Initiative Policy Manual instructions.
- Apply the appropriate modifier to the appropriate HCPCS/CPT code if a combination of HCPCS codes and CPT codes is required.
- Note that vaccine toxoid codes, 90476 to 90748, identify the vaccine product only. To report the vaccine/toxoid, the administration code also must be reported for same date of service. Refer to AMA CPT guidelines for more details.

Questions may be submitted using the "Code Editing Questions" application on the secure provider area of Humana's website, Humana.com/providers, by following these steps:

- On Humana.com/providers, select "Log In"
- Enter your user ID and password and select "Log In"
- Choose the "Claims Tools" tab
- Select "Code Editing Questions" under "Associated Links" to submit your question(s)

In order to access the "Code Editing Questions" application, you must be registered on Humana's website. If you haven't registered, please follow these instructions:

1. On Humana.com/providers, select “Register”
2. Select “Provider” on the “Please tell us who you are” screen to start the provider registration process
3. Follow the instructions on each page as you move through the application process

Once the registration process is complete, you will be able to access “Code Editing Questions” and submit questions on the secure provider area of Humana.com/providers.

Humana Prepares for ICD-10 Transition

As health care providers are aware, all entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must transition to using ICD-10 codes by October 1, 2014. This includes both Medicare and commercial lines of business.

Humana will go live with the ICD-10 codes effective October 1, 2014.

Health care providers should be aware of the following important information about Humana’s preparations for the transition:

- Humana will accept ICD-9 codes on claims with a date of service (DOS) or discharge date of September 30, 2014, or prior. Humana will accept ICD-10 codes on claims with a DOS or discharge date of October 1, 2014, or after. ICD-10 codes will not be accepted before the implementation date.
- Humana is investing in remediation of systems and processes to support the ICD-10 requirements. Humana does not foresee any issue with claims processing with the change to ICD-10, although rejection due to misuse of new codes is possible. Testing will help mitigate such issues.
- Humana will process claim transactions in their “native” format and will not be using GEMS to crosswalk ICD-9 codes to ICD-10. Claims with improper diagnosis codes (based on date of service or date of discharge) will be rejected.
- Humana will support both ICD-9 and ICD-10 coding formats for a period of time after October 1, 2014; however, Humana will only accept correctly formatted claims, both electronic and paper, which contain ICD-10 codes for dates of service and discharge dates of October 1, 2014, and after.
- Humana is planning to initiate external end-to-end testing with a select group of early adopters during the third and fourth quarters of 2013.
- Humana suggests that health care providers stay informed about changes from the Centers for Medicare & Medicaid Services (CMS) regarding ICD-10 implementation by visiting the CMS website (http://www.cms.gov/Medicare/Coding/

ICD10/index.html?redirect=/icd10). If health care providers have questions or concerns, they may submit an email to ICD10inquiries@humana.com.

- Health care providers can find more information at Humana's ICD-10 Web page (http://www.humana.com/providers/claims/icd-10/).

Staff Preparation is Key in Transition to ICD-10

Preparation of a medical practice's office staff is a key element to the transition to ICD-10. All medical coding staff will need training on how to use the new ICD-10 codes. Health care providers are encouraged to implement a training schedule to ensure that coding staff is ready for the October 1, 2014, transition. Also, any staff member who will be involved in testing systems will need appropriate training to ensure successful testing.

New Pilot Seeks to Encourage Minimally Invasive Procedures

Humana, along with Ethicon Endo-Surgery Inc. is piloting a new program to share the advantages of minimally invasive procedures (MIP) with health care providers and their patients with Humana commercial coverage.

Once individuals have exhausted other treatment alternatives and surgery becomes a necessary procedure, providing the option of a minimally invasive procedure may improve clinical outcomes, decrease the length of hospital stays and bring a faster return to normal activity, as well as lower health care costs, when compared to standard open or abdominal surgery.

MIP is performed through small incisions or a natural orifice using video cameras and specialized instrumentation. This approach is often referred to as laparoscopic surgery.

Using MIP, when appropriate, has many advantages. When compared to open surgery, a minimally invasive procedure may mean:

- Shorter hospital stays
- Less recovery time
- Less scarring
- Less post-operative pain
- Less risk of hospital-acquired infection

The following four Shared Decision-Making guides provide information for health care providers and their Humana-covered commercial patients to use when considering MIP options to traditional open surgery. The guides will give health care providers information needed to counsel their patients on MIP options. The guides are:

- Colectomy (http://apps.humana.com/marketing/documents.asp?file=2100501)
- Bariatric/Metabolic Surgery (http://apps.humana.com/marketing/documents.asp?file=2100514)
- Hysterectomy (http://apps.humana.com/marketing/documents.asp?file=2100514)
- Obesity Management (http://apps.humana.com/marketing/documents.asp?file=2100527)

Minimally invasive procedures have been proven to have the same efficacy as traditional surgery. Humana's current pilot hopes to reinforce this information by sharing the four Shared Decision-Making guides with groups in Miami-Dade and Broward counties. If successful, these tools will be made available to all Humana members and participating physicians in all markets.

Online Tools, Presentations, Webinars Provide Important Tips to Providers, Staff

Humana adopts clinical practice guidelines based on guidance from national organizations generally accepted as experts in their fields. When available, Humana's YourPractice features updates to these clinical practice guidelines and new guidelines adopted. Humana's intent is to provide timely information about evidence-based best practices for patient care as well as help improve quality measures and star scores. While many guidelines are updated annually, others may not change for several years. Humana encourages health care providers to look for these clinical practice guideline notifications in each issue of Humana's YourPractice. Medical and behavioral health clinical practice guidelines are available at http://www.humana.com/providers/clinical/clinical_practice.aspx.

Updated Clinical Practice Guidelines

- Asthma Guidelines – updated April 2012.
- Colorectal Cancer Screening Guideline was removed as a separate guideline. It is now included in the general Cancer Screening Guidelines.
- Cancer Screening Guidelines have a new website (http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer) that was last updated May 2013.

New and Revised Medication and Medical Coverage Policies

Humana's medical and medication coverage policies are based on evidence published in peer-reviewed medical literature, technology assessments obtained from independent medical research organizations, evidence-based consensus statements and evidence-based guidelines from nationally recognized professional health care organizations.

Information about medical and medication coverage policies can be found on Humana.com/providers by selecting "Medical Coverage Policies" under "Critical Topics." Medical and medication coverage policies can be reviewed by name as well as revision date. Users may also search for a particular policy using the search box. More detailed information may be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process."

Below are the new and revised policies:

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New Medication Policies

- Diclegis (doxylamine succinate and pyridoxine hydrochloride)
- Xofigo (radium Ra 223 dichloride)
- Procysbi (cysteamine bitartrate)

Medication Policies with Significant Revisions

- No medication policies with significant revisions

New Medical Policies:

- Gender Reassignment Surgery

Medical Policies with Significant Revisions:

- Intra-operative Neurological Monitoring
- Intrauterine Fetal Surgery
- Orthognathic Surgery
- Speech Therapy
- Tinnitus Treatments
- Tumor Markers for Diagnosis and Monitoring of Cancer
- Attention Deficit Hyperactivity Disorder (ADHD) Diagnosis and Treatment
- Genetic Testing and Counseling for Hereditary Cancer Syndromes
- Mobility Assistive Devices (Wheelchairs)

- Nerve Conduction Testing, Somatosensory Evoked Potentials
- Stereotactic Radiosurgery (SRS) – Gamma Knife®, Linear Accelerator, Cyberknife®

Retired Medical Policies

- Carotid Artery Stenting
- Terbutaline Infusion for Preterm Labor

Online Presentations Make It Easier to do Business with Humana

Humana's "Education on Demand" tool provides health care providers and their office staff members with quick, easy-to-understand presentations on topics that should make it easier for them to do business with Humana.

To access these presentations, health care providers may choose: https://www.humana.com/provider/support/on-demand/. If a computer with a sound card is not available or if the computer is not configured for streaming audio, the presentations are available over the telephone while viewing the slides on screen. To begin the telephone playback process, health care providers should follow these steps:

- Click on the question mark in the bottom right corner
- Select "Player Settings" from the pop-up box
- Check "Use telephone playback with standard player"
- Click the "Submit" button
- A window will open displaying the telephone number and access code that need to be dialed to receive the audio

Available presentations are as follows:

- How to do Business with Humana
- RadConsult™ Online
- SmartSummary℠Rx
- Texas Deficiency Tool
- Humana's Quality Initiatives

The presentations can be accessed around the clock.

Webinars Provide Interactive Learning

The webinar sessions below will assist health care providers in learning how to utilize Humana.com to save time, increase efficiency and help improve the productivity of their practices. These sessions for provider office staff last between 45 minutes and one hour.

2013 Provider Webinar Training Schedule

Humana.com Overview

This webinar provides information about Humana.com's self-service tools available for health care providers. Providers can expect to learn more about eligibility and benefits, referrals and authorizations, claims tools, remittance inquiry, fee schedules and more.

- 2 p.m. EST, Tuesday, September 10
- 11 a.m. EST, Tuesday, October 8
- 11 a.m. EST, Wednesday, November 13
- 2 p.m. EST, Tuesday, December 10

Eligibility and Benefits

This webinar teaches how to submit online requests for verification of a patient's eligibility and benefit information. Instant results include covered services, copayment and deductible information. Health care providers will also learn about the member ID card viewer, member summary and Humana's new benefit estimator tool, which provides a real-time estimate of a patient's payment responsibility for professional services.

- 11 a.m. EST, Friday, September 6
- 11 a.m. EST, Thursday, October 3
- 2 p.m. EST, Thursday, November 7
- 11 a.m. EST, Thursday, December 5

Referral/Authorizations

With the Referral and Authorization tool, health care providers can easily submit requests for both inpatient and outpatient services. This webinar will teach how Humana's authorization management tool can help health care providers check the status and make changes to existing referrals and authorization requests.

- 2 p.m. EST, Wednesday, September 4
- 2 p.m. EST, Tuesday, October 1
- 11 a.m. EST, Tuesday, November 5
- 11 a.m. EST, Tuesday, December 3

Claim Tools and Remits

This webinar teaches how to reconcile and manage accounts receivable by reviewing claims status, results and remits online. Health care providers will learn how to make corrections to professional claims, send attachments, view and download remittance advice.

- 11 a.m., Thursday, September 12
- 2 p.m. EST, Friday, October 11
- 11 a.m. EST, Friday, November 15
- 2 p.m. EST, Friday, December 13

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

This webinar includes instruction on how to get payments faster by registering for electronic funds transfer and how to receive electronic remits either through a clearinghouse or Humana.com. The webinar also walks through the registration process.

- 2 p.m. EST, Tuesday, September 17
- 2 p.m. EST, Wednesday, October 16
- 2 p.m. EST, Tuesday, November 19
- 2 p.m. EST, Tuesday, December 17

Benefit Estimator

This webinar instructs health care providers how to create a real-time estimate of a patient's payment responsibility for professional services. These estimates are specific to each health care provider's Humana provider agreement and the member's benefit plan.

- 2 p.m. EST, Tuesday, August 22
- 2 p.m. EST, Thursday, September 19
- 11 a.m. EST, Friday, October 18
- 2 p.m. EST, Wednesday, November 20
- 11 a.m. EST, Thursday, December 19

Medical Records Management and Resources

The Medical Records Management (MRM) tool allows providers to view requests made from Humana for most medical records. Health care providers who attend this webinar will learn how to manage, submit and close these requests. Also,

the webinar teaches how to make demographic changes, view and download contracted reimbursement rates and more.

- 11 a.m. EST, Tuesday, September 24
- 2 p.m. EST, Tuesday, October 29
- 11 a.m. EST, Tuesday, November 26
- 2 p.m. EST, Monday, December 30

ICD-10 Readiness for Provider Offices

Learn about ICD-10 readiness and what Humana is doing. The target audience for this call includes practice managers, physician office managers, medical coders, physicians, physician office staff, nurses and other nonphysician practitioners.

- 11 a.m. EST, Friday, September 20
- 2 p.m. EST, Tuesday, October 22
- 2 p.m. EST, Thursday, November 21
- 11 a.m. EST, Friday, December 20

ICD-10 Readiness for Facilities

Learn about ICD-10 readiness and what Humana is doing. The target audience for this call includes patient financial services, authorizations staff, revenue cycle managers, hospital billing associates, health records staff, vendors, laboratories and system maintainers.

- 2 p.m. EST, Tuesday, August 20
- 2 p.m. EST, Monday, September 23
- 11 a.m. EST, Thursday, October 24
- 11 a.m. EST, Friday, November 22
- 2 p.m. EST, Monday, December 23

How to Register

To register, send an email to deployment@humana.com.

When registering, please include the following information in the subject line of the email:

Webinar Registration – DATE OF TRAINING (ex: 12/20/13)

Please also include the following information within your email:

- Name of main participant
- Practice name
- Phone number
- Email address(es) of participant(s)
- Tax ID Number
- Number of participants attending the webinar

Confirmation and instructions on how to access the online webinar will be sent via email within 48 hours of your request.